



Inpatient Coding Guidelines

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General Guidelines

- Use both Alphabetic and Tabular Index
- Level of Specificity in Coding
 - Use highest level of specificity
- Other NEC and Unspecified (NOS) Code Titles
 - Used only when neither diagnostic statement nor a thorough review of the medical provides adequate information to permit assignment of a more specific code.

General Guidelines cont'd

- Acute and Chronic Conditions
 - Code both and sequence acute (subacute) code first when condition described as both acute and chronic
- Combination Code
 - Single code used to classify two diagnoses or a diagnosis with an associated secondary process (manifestation) or associated complication

General Guidelines cont'd

- Multiple Coding of Diagnoses
 - Required for certain conditions not subject to rules for combination codes
- Late Effect
- Residual effect (condition produced) after acute phase of an illness or injury has terminated.

General Guidelines cont'd

- Uncertain Diagnosis
 - Diagnosis documented at time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out,” code the condition as if it existed or was established.

General Guidelines cont'd

- Impending or Threatened Condition
- Condition described at time of discharge as “impending” or “threatened” as follows:
 - If it occurred, code as confirmed diagnosis
 - If it did not occur, reference the Alphabetic Index for subentry term or main term for “impending” or “threatened”
 - Assign given code or existing forerunner condition(s) and not the condition described as impending or threatening

Selection of Principal Diagnosis

- Circumstances for inpatient admission always govern the selection of principal diagnosis
- Principal diagnosis defined by UHDDS as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care

Selection of Principal Diagnosis

- Volumes I, II, and III take precedence over all other guidelines in determining principle diagnosis
- consistent, complete documentation in the medical record is a must
- Without accurate, complete documentation it is difficult, if not impossible to apply all of the coding guidelines

Indiscriminate Multiple Coding

- Avoid indiscriminate multiple coding
 - Irrelevant information (i.e. signs and symptoms integral to the diagnosis)
 - Diagnostic tests (i.e. laboratory, x-ray, or electrocardiographic tests), unless diagnosis confirmed by physician
 - No code assigned for conditions which fail to meet UHDDS criteria for reporting
 - Unspecified codes when more specific code assigned

Unconfirmed Diagnoses

- **Code unconfirmed diagnoses as if established (inpatient setting)**
 - Diagnoses for inpatient at time of discharge qualified as “possible,” “probable,” “suspected,” “likely,” “questionable,” “?”, or “rule out,” condition should be coded and reported as though diagnosis established
 - Exception applies to HIV infection/illness
 - code only cases confirmed by physician documentation)

Rule Out vs. Ruled Out

- Important to distinguish between terms “rule out,” which indicates a diagnosis is still considered possible, and “ruled out,” which indicates a diagnosis originally considered likely is no longer a possibility
- Diagnoses qualified by the term “rule out” are coded as if established for inpatient episodes of care in the same way as diagnoses describe as possible or probable

Rule Out vs. Ruled Out cont'd

- Diagnosis described as “ruled out” are never coded
- Alternative diagnosis should be coded, otherwise code for presenting symptom or other precursor condition should be assigned